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HUDSON VALLEY REGIONAL EMERGENCY

MEDICAL ADVISORY COMMITTEE

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MINUTES OF MEETING, held at the offices of Hudson Valley Regional EMS, 33 Airport Center Drive, New Windsor, New York, on Monday, June 1, 2015, at 9:30 a.m.

Yvette Arnold,
Court Reporter

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A P P E A R A N C E S :

DR. ERIK LARSEN,
Acting Committee Chair

WILLIAM HUGHES, EMT
HVREMSCO Executive Director

JEFFREY CRUTCHER, QI Coordinator

CATSKILL REGIONAL MEDICAL CENTER

DR. ANUJ VOHRA,
Physician Representative

GOOD SAMARITAN HOSPITAL

DR. DENNIS MAO,
Director

HEALTH ALLIANCE OF THE HUDSON VALLEY

DR. AMY GUTMAN,
Director

NORTHERN DUTCHESS HOSPITAL

DR. WILSON,
Director

NYACK HOSPITAL

DR. MARK PAPISH,
Director

DR. SACHIN SHAH,
Physician Representative

A P P E A R A N C E S : (Continued)

ST. FRANCIS HOSPITAL/MID HUDSON REGIONAL HOSPITAL OF WMC

DR. ARSHAD,
Director

DR. BERKOWITZ,
Physician Representative

SHARON HOSPITAL

DR. BENNEK,
Physician Representative

WESTCHESTER REMAC LIAISON

DR. ERIK LARSEN,
Physician Representative

ALSO PRESENT:

DAVE VIOLANTE
ANDY LAMARCA
MIKE BENENATI
RICHARD PARRISH
MICHAEL MURPHY

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DR. LARSEN: Folks, we are going to start. Evidently -- hopefully Pam still may show up, we have not heard from her. And Eric Stutt is out of town, so I've been asked to stand in since I'm actually a nonvoting member, so I'm somewhat neutral -- or powerless -- not neutral, but powerless.

So anyway, why don't we move ahead and make sure that everyone -- why don't we send this around and actually get this -- everyone to check their line. Is that fine?

MR. HUGHES: That's fine.

DR. LARSEN: So should we do the roll call -- so people are going to checkoff, okay?

In reviewing the minutes, any corrections, any changes, any objections?

DR. MAO: Motion to approve.

DR. LARSEN: Second?

DR. BENNEK: I'll second it.

DR. LARSEN: Vote. All in favor?

ALL: Aye.

DR. LARSEN: The minutes of the last meeting of March have passed.

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Old business, the 2015 collaborative protocols roll out update?

MR. HUGHES: I can do that. We have eight providers that didn't complete the roll out throughout the system, but we do have some issues with some of the hospitals. We are missing some physicians out of Sharon Hospital and Hudson Valley Hospital. And we have not received any paperwork for the physicians to be rolled out in Bon Secours, Catskill Regional, Putnam, St. Anthony's, Westchester Medical, and Nyack Hospital. So we would appreciate it if you can get that information to us so that we can have a record that everybody has completed the roll out. All right? Thank you.

DR. SHAH: I'm assured Nyack is compliant.

DR. PAPISH: I'll e-mail it, I have it.

MR. HUGHES: I'm sure everybody is, it's just we don't have the paperwork.

DR. LARSEN: It's simply a letter that just says that you have reviewed and are in compliance with the roll out, so just a

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simple letter.

Spinal immobilization update. There have been -- I think there has been some progress at State level, would you like --

MR. MURPHY: I can speak to that since I sit on the State Council. The last part of the day I actually entered into the record and asked the question when will the spinal immobilization materials roll out, et cetera, be available? And Lee Burns assured me that it would be by the next State Council meeting, which was originally supposed to be September. However, some problems with dates and meeting times and availability of the hotel, et cetera, it's now been pushed to December. So actually what I think we should do is try and hold them to that September timeline.

DR. LARSEN: Any -- anything --

DR. ARSHAD: So basically some statements, similar challenges all across the State. I think our goals as a community are to continue to educate on best practices. The evidence is -- essentially it speaks for

itself. I know Dr. Berkowitz and I have both been doing some work and with Dr. Mao at the regional conference in Orange recently we have been doing a lot of education on the updated literature, the consequences and adverse outcomes of long boards as used for patient transportation. We do still support for patient extrication. Nevertheless, we have to obey state protocols so we have to -- we are waiting for them.

DR. LARSEN: Okay. So how do you think we should move forward then on making the SEMAC hold to the September date? What can we do? Any suggestions along those lines?

MR. LAMARCA: I think, again, attending the State Council, I think the SEMAC and medical standards were very very aggressively trying to push the department to, you know, get a final date. We thought it was going to be about six weeks, then they said to the next meeting. Their concern is they have to change -- other than just the protocol they have to change the educational template, have to change the exams, the practice skills

exams and they don't think they could do it in a timely manner. I think we can argue if we put a couple of those people in a room we should be able to get it changed in a couple of days. As Mike said, they are pushing it to the next meeting as just -- that's their end game. They may do it before that, but there is no way to put pressure on them. But similar to what they brought up as far as blood infusion issue, they are ready to -- the members of SEMAC and medical standards want to go to the Commissioner and ask the Commissioner to expedite this. I don't know if they will be successful. So I don't know as a region if we can do much more than that to really try and kick start this.

MR. MURPHY: Just to echo what Andy said, the entire SEMAC, entire SEMSCO, training committee, everybody is like, where is it? So it's -- the ball has been in the DOH's court for a while now. We got them to a timeline that SEMAC needs to hold them to, I don't know what else to say unless people start going to the Commissioner directly.

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MR. VIOLANTE: Is there something we are doing at the Regional level for all our providers to make it easier for them? Because I know a number of people that are really confused from agencies -- at least around Dutchess County where there is amazing and good education, which is very appropriate and everybody knows this and does some of their own --

(The speaker cannot be heard.)

MR. VIOLANTE: -- best practices and they are still confused about we have to follow what the State says, is the -- if the Region is supporting us if we don't and call medical control for the instance by instance and is there anything we are doing to make sure our providers are in accordance and know where this is aside from us getting information out? Okay, too many questions --

MR. LAMARCA: I think that both the State and we have made the statement that in essence the providers are held harmless, if indeed they do not choose to immobilize. Again, I think that's like a little bit of a

pregnant pause in-between the education we know they need and the preparation for it and some ER's asking, why are you still putting a patient on a backboard? But they are in a little bit of a quandary here. We have gotten shot down -- as did New York City -- in our efforts last time to see if we can fast track it with a more Regional sort of solution and the State told us not to do that. I don't think we can change much on our level. Now it's almost like letting it occur, if they didn't backboard, fine, and if they do backboard, also fine --

DR. ARSHAD: I give them high fives if they don't backboard --

MR. VIOLANTE: So that's clearly a medical control option, is that correct?

DR. ARSHAD: Right. That's what would I argue as an option for prehospital providers. If you -- the patient meets the criteria why not discuss the case with on-line medical control?

MR. VIOLANTE: So maybe something that can come as a solution from this body is that

it's very clear we are waiting for the State on this issue, a lot of good education is out there, get some. If you have a question about whether your patient needs spinal mobilization contact medical control and make sure that is documented on your prehospital care report and that should cover everybody. It's a solution. Every provider can get the information, we can send it out and that's the stance of the Region at the moment.

DR. LARSEN: Do we need to formalize that? We sort of did last time, I believe. I mean --

DR. ARSHAD: It's a reasonable option. If we make it on-line medical control we would as representatives for the MAC have to touch base with the remainder of the providers in the emergency department to expect an uptick in calls of this nature. And we have to do a better part as MAC representatives to educate physicians, as well as nursing colleagues, because we have a lot more to do in terms of education to fully overcome that hump especially in New York

State.

MR. VIOLANTE: As Andy said, in that sort of pause in-between where it's starting to happen we want to make sure our providers in hospital and out of hospital are covered appropriately and don't get into a jam by anybody.

MR. LAMARCA: I really think most of the issue being discussed, we are going to just put a collar on and gently stabilize the patient. But I think the concern from some people is, all right then, what is the few remaining times when we would want a backboard and fully immobilize? I think that is what is giving the State problems in how to clarify and not really putting backboard on everybody, that's part too. We have to make sure they understand there will remain, by all admissions, a minority of people that still need for safety's sake to be on a backboard.

DR. ARSHAD: I think that's -- we are making a big deal about the training. I think it's still a requisite skill on BLS and

ALS level. If you have a medivac and you are placing the patient in a scoop stretcher, so long board maybe part and parcel of medical evacuation. It's still something practiced by prehospital care providers, it's still something we need to teach them, it's just giving them some wiggle room for best practice when it comes to use in transport rather than extrication.

DR. BENNEK: What you are saying is the training isn't such a big issue, that seems to be the hang-up from the State. On the other hand what you are really doing is just changing the verbiage. You are --

(Everyone is speaking at once.)

DR. BENNEK: -- the indications have changed. That's not a big deal, I mean --

MR. LAMARCA: I appreciate that, but I think training the lowest common denominator, that's a problem.

MR. VIOLANTE: So we are still covered by the last thing, do we need --

DR. ARSHAD: Because -- parliamentary procedures are not my area of expertise. I

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know in the last meeting we had written an advisory, was that carried forward, or is that not part of the record? I was unclear what happened --

DR. LARSEN: No, that would carry forward.

DR. ARSHAD: So that advisory is passed. We should distribute that again and indicate what exactly are your indications for usage as a means of protection.

DR. MAO: Another thing is, we have the collaborative protocols. Let's muster up the other regions and put up -- five or six of us put out one advisory as a group, we can get the State and push the issue with that support.

MR. LAMARCA: You can, I think it's going to take some more time to get that down.

DR. LARSEN: So we have the -- we have what we had last time.

My question is, have people gone ahead with education programs within the EMS community here? Because, I mean, there is

nothing that is holding back doing the education. I mean -- you know, yeah, it's a little bit well, we are doing it ahead of time. What is the problem with that? There is no problem with that. We are just waiting for the official sort of drop dead deadline. But if everybody was ramped up ahead of time it would be no big deal whether it came in September, or unfortunately if it waited until December.

SPEAKER: Just to interject, the quandary you run into is they are still being tested to the old standards. So when you change an education you can't say, by the way, here is best practice, but here is what you are going to test on. The end user wants to know what they are going to be evaluated on --

DR. ARSHAD: We hear this often, testing is a concern for us, but our priority as a medical body is optimal patient health. And when we have clear evidence that immobilization in a rigid long board is harmful, we have to be as diligent as

possible in educating providers in trying to mitigate that --

(The speaker cannot be heard.)

DR. ARSHAD: -- the social media articles published on daily basis so we have to represent best patient care.

MR. LAMARCA: I know we are running a bunch of base level -- re-running a number of basic EMT programs that finish and test in the next month, they have to test to the existing standards. We caution them, as soon as you are finished you probably want use the backboard as --

(The speaker cannot be heard.)

MR. LAMARCA: -- I agree with you, I think we all feel like -- we feel guilty --

DR. ARSHAD: My approach in the CMEs that we do on long boarding, I think we are sharing with about 250 participants in the community thus far -- we describe the evolution of science, right, so we go all the way back to the late 1960s. And we describe -- I put on the screen the papers where long boarding was developed as a

concept. Two patients, right? And we advance the science paper after paper and the evolution and incorporate now the guidelines by NAEMSP, as well as the combined by the American College of Surgeons, and ACEP in January issued brand new guidelines for EMS long board. So when you spin or portray as evolution in science and they get to participate in evidence based medicine, it's an almost uplifting story and they are learning about EMS research and how we advanced in science.

DR. BENNEK: I wonder if there is any advantage to making a plea to the State and we state, by delaying patients maybe harmed --

(The speaker cannot be heard.)

DR. BENNEK: Why would they delay it until January? It doesn't make -- or December? Why would it make sense to put patients in a position where they might be harmed because of a delay in protocol? We can't force them to do anything, but isn't that some leverage --

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MR. LAMARCA: In reality it should be, but it --

MR. MURPHY: That was exercised numerous times in medical standards and the SEMAC State body. That argument has been done quite often and still the road block is we will get it by the September meeting -- which is now December -- so everybody, providers, educators, physicians, have all in their own different silos and electively have tried to hammer this approach forward. And what Dr. Arshad said, it's easy to train and do existing providers, that's easy. That will go -- we have been telling you for years the backboard is useless. That's an easy thing. What Dave is talking about, we are stuck in the quandary that original providers, that we have to do certain collective standards and certain testing and that's the problem with the originals. With the certified personnel out there practicing already, that hump is easy to overcome, many people understand and we have been teaching all along. I think it will take a couple months just to get this

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together, but that argument has been made at the State level.

DR. BENNEK: Does a letter come from this committee, folks? I'm thinking about the political pressure that goes on -- you write the Senator or representative a letter. In other words, I'm asking will this committee write a letter saying you guys, by delaying, may be causing harm to patients? It may have impact, I don't know.

MR. MURPHY: That would not hurt, that would help. Send a letter to --

DR. BERKOWITZ: I think the advisory did sum our feelings towards this issue. I think that relative to the blood issue this is moving exponentially faster. This is amazing. So you know, I think in an interim period, I think what Andy said is true, we have to make sure it's a hold harmless mentality. We are not going to scream at people and be upset. There is no evidence to support it, but at the same time people who are training are going to be trained as they can't be trained for standards we anticipate

in the future, then we could invent all sorts of stuff. Obviously, you can't do that. They will be trained on the standards and be educated when they change. But, you know, if we get this done in September or December, that's great. It's still pretty good. I mean, I'm actually more worried we will get this done before the blood part gets done and the blood part is just as much of an issue, if not more so, especially with reasonablization (sic) of trauma and, you know, what will happen to trauma patients in the Region. So I think, you know, hopefully September, maybe December.

MR. LAMARCA: We will have more on the blood products in a minute. Just to give Dr. Murphy credit, we were talking during standards on SEMAC and Pam brought up as a last ditch effort, why don't we contact the states that have already made the change and copy what we need from their training to testing and everything else and it would fast track it. And it was no, New York has to do it their way.

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SPEAKER: I don't understand what the main hold up is -- just listen to me for a second. Number one, yes, we have a standard we have to train to, and that's fine. We are not saying there is absolutely 100 percent no time they are going to use this skill, so they still have to be taught. So what difference does it make that we have to teach it to new EMTs coming out? Once they graduate and are operating in the field it's up to their individual agencies to get them on board with what their practices are. So I certainly don't understand -- we are having this huge hold up on what the Region is doing versus what the State training is. The State SEMAC put out an advisory that they are saying we understand this is an issue and it's not in the best practice. Okay, the Region has already said we are willing to support this and willing to support the providers not immobilizing the patients. We are not saying there is 100 percent of the time you are not going to do this and you don't need another skill. So as an

instructor it doesn't make a difference, we are still teaching the skill. So why? Why are we beating our heads on this?

MR. LAMARCA: Kevin, we are not, the Department of Health will not let us go forward. That's all you have to understand. At this point in time they control our ability to generate the changes, the protocol we need. So at this point in time it's the rest of the world against the State Health Department.

DR. ARSHAD: Along those lines, EMS week -- I held an EMS New Jersey where I invited Dave Cohen, who in Connecticut has been getting rid of long boards --

(The speaker cannot be understood.)

DR. ARSHAD: -- Pennsylvania has gone long board free for the State and they had remarkable insights. And we were on social media for the event and it generated a lot of buzz, but it didn't move the meter at all with SEMAC or SEMSCO.

MR. LAMARCA: SEMAC and SEMSCO are in lock step with us to do it, it's the

department, pure and simple. And if you send a letter about it to the Commissioner, if you ask the collaborative regions, send it to the Commissioner, they have directed the Chair to address it to the Commissioner.

DR. LARSEN: Any further comments on this issue?

I guess going to service upgrades?

MR. HUGHES: No service upgrades.

DR. LARSEN: Evaluation subcommittee report?

MR. HUGHES: There was no violations or anything that was brought forth.

DR. LARSEN: Anything from the Helicopter Committee?

MR. HUGHES: I spoke with Dr. Stuhlmiller this morning, he apologizes for not being here, but he had an issue at home. But he did have no report.

DR. LARSEN: Quality improvement report?

MR. CRUTCHER: Progress towards the Nemesis 3 bridge is continuing. Image Trend is hopeful they will have that working for us in the next quarter. In the interim they

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have given us a version two complete bridge that we will start to migrate agencies onto. So that will be the interim step prior to the data being distilled and sent to Nemesis and the State.

DR. LARSEN: Any comments?

Moving on to new business. So CPAP for BLS providers, that's this multi-page stapled document --

MR. HUGHES: Comments on that?

DR. LARSEN: Yeah.

MR. HUGHES: Okay, the CPAP for BLS providers was a pilot program done through SEMAC and through SEMSCO and has been passed that it's a skill that can be done by BLS providers throughout the State. The program does require several things, one is that the REMAC, which is this group, approves that we use CPAP on the BLS level within our region. The second is that we have a State approved SEMAC training program that has been -- I believe it's four hours of didactic and one hour of clinical and then remediation testing and skills. So over the last week we had a

lot of inquiries from a lot of agencies and there was a couple things that happened. One, we put together a program that we thought was sufficient. We sent it to the State and we did get a State approved program for our Region if we want to do that. The second thing is, we kind of have the cart before the horse on this one. The REMSCO meeting, which approves this stuff after we are done here, with certain things that can be disseminated out to the Region, approved CPAP for BLS if under the condition that we approve it here at the REMAC meeting. So if it's approved here then we could then deploy it out to the agencies.

So we do have -- we have done a lot of work on this. There has been a lot of agencies requesting the paperwork and the permission and authority to go out and use CPAP. So I don't want to bring it up and discuss topics -- anybody have questions, topics, anything they feel strong about?

DR. LARSEN: Are any of you directors of BLS agencies that have asked for this, or

your experience -- what has your experience been?

DR. PAPISH: They are asking for it.

DR. BENNEK: I would say CPAPs are loud on the Connecticut side of the BLS looking for training, so there is interest. I haven't heard anything on the New York side. I have a few squads on the New York side, which is why I'm leery, but they haven't requested. But on the Connecticut side I think the squads are interested so once it's put out there as a possibility I think there might be interest. At least that's my experience with that.

DR. GUTMAN: I know it's a little more Mid West, but we used it in Cincinnati --

(The speaker cannot be heard.)

DR. GUTMAN: -- transports and we cut our intubation 45 minutes to like zero intubation within about three months of implementing this program and hugely successful, very well-implemented. And from the hospital perspective we thought it was a great program.

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DR. LARSEN: Okay, very good.

MR. HUGHES: We do need a roll call vote on that.

DR. LARSEN: Okay. All those in favor of implementing as outlined in the policy statement? I guess I should -- it would be number 15-02, continuous positive airway pressure, CPAP, for BLS EMS agencies.

Do we have a second?

DR. BENNEK: I'll second.

DR. LARSEN: And a vote. All in favor say aye?

ALL: Aye.

DR. LARSEN: Opposed? Abstain? It passes, good.

I guess we are not having this -- this is what? Town of Warwick Volunteer --

MR. HUGHES: I had mis-scheduled that. They did not implement until February so the Town of Wallkill will be at the next September meeting so we have rescheduled that with them.

DR. LARSEN: SEMAC report? We had part of it, Pam was supposed to give that. Anyone

else --

MR. LAMARCA: I think we can all chip in perhaps, but obviously as it did here, the spinal preoccupied a lot of the discussions.

The other thing is the administration of blood during the interfacility transfers, which is supposedly into its second review and edits and should be ready for the Commissioner's signature. And, again, very passionate pleas were made by SEMAC representatives that people were dying without being able to administer blood. So they asked that the chair write a letter, strongly worded, to the Commissioner to tell him the delay is obviously unacceptable. That's where it's left. I don't know if there has been any urging of the Commissioner to expedite this. But the Commissioner has run him through the ringer on this a number of times with the little edits and they wait until the last minute until they announce an edit and it's dragging it along. So the State knows in many cases we are transporting with bloods running, but not initiating any

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blood product on our own. But taking from the hospital, the State Department, they know and all the SEMAC physicians have voiced they will support any service that has to do that just because of patient necessity. But that was about it on that.

Mike, anything else significant you remember?

MR. MURPHY: It was that issue with the rectal Valium --

MR. LAMARCA: That it should not be implemented, no rectal medication --

MR. MURPHY: Yes.

MR. LAMARCA: No one opposed? That was a quick discussion.

DR. LARSEN: So those are the basic three main discussions?

MR. LAMARCA: There were a number of smaller things, but I don't have any notes --

MR. HUGHES: One of the things that did come out of there was another pilot program for -- its called check and inject, which is for epi -- replacement of Epipens with BLS injectable epi. So Dr. Dailey, who is from

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the REMO region, spearheaded a project, a pilot project, that will allow EMTs to use epi injectably -- to inject them --

MR. LAMARCA: Draw and inject it --

MR. HUGHES: Right --

MR. PARRISH: What they have done is following the King County, Seattle, Washington where they have been successful. Epipens are $350.00, this particular kit is $55.00. They made arrangements to get a special syringe built, 50,000 of them. It will have two marks, one for peds and you just draw it up to peds level, or adult, you draw up to adult level. They are looking for people to participate in it. If you are interested you contact Dr. Dailey, it's statewide, not just limited to one particular area. And that's where this check and inject sheet comes from. There is five doctors that will be on-call 24/7 so when you do it you call them, update them if there is any issues with it, so they can move it forward --

MR. HUGHES: The caveat with that is that they will not allow the agencies within

the Region to participate unless the REMAC -- our regional REMAC feels it's sufficient we do participate. So we do need to say yes or no for our agencies to participate in the pilot. The control and all the information and all the reporting that would have to be done by the agencies will have to go through a central reporting group that will be setup. And each usage will be discussed with one of the physicians that are in that group. So it's whether or not we want as a Region to let our agencies participate in that program.

MR. PARRISH: They did -- like Dr. Dailey said -- a back of the envelope calculation and they feel we are throwing away about $10 million a year in Epipens. They are only good for like 18 months so by doing this they can reduce that cost.

MR. HUGHES: Our region, as far as we can tell at this point from the information we have, we had twelve Epipens for adults and two for pediatrics in 2014.

DR. ARSHAD: Were they all for anaphylaxis, or any BLS responding to cardiac

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arrest?

MR. HUGHES: Anaphylaxis.

MR. VIOLANTE: Any for asthma post albuterol?

MR. CRUTCHER: Not that I was able to determine, it seems all anaphylaxis related.

MR. LAMARCA: One of the --

(Everyone is speaking at once.)

DR. PAPISH: It seems shockingly low for the whole Region for the year --

(Everyone is speaking at once.)

MR. LAMARCA: -- a lot of ALS given too.

MR. HUGHES: It's strictly the BLS so --

MR. LAMARCA: Dr. Dailey reported that if you buy the Epipen out of Canada it would be $100.00, but we can't --

(Everyone is speaking at once.)

DR. BERKOWITZ: Do we have an idea how many Epipens we need -- you said 12 total patients in the Region, how many Epipens are actually deployed?

MR. LAMARCA: In ambulances, usually two adult, one pediatrics.

DR. BERKOWITZ: And they expire in

12 months.

MR. PARRISH: You have to be careful when you get your shipment, like from Moore, to make sure you have the full 12 months.

DR. SHAH: What is the expiration on the vials?

MR. PARRISH: Basically the same, but cheaper.

MR. LAMARCA: The expiration is on the actual vial. It said the kit will have the expiration right on the kit.

DR. SHAH: But if expiration on the vial is three or four months, it's the same thing.

MR. LAMARCA: I don't know what expiration is on Epipen one thousand, but --

SPEAKER: I had two and a half years on the last --

(Everyone is speaking at once.)

MR. PARRISH: The kit would be sealed and will have -- for the pilot will have a tracking number on it and the expiration date will be the expiration that is on the vial that is in there.

MR. LAMARCA: They are producing 50,000

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of them so they will distribute, I guess --

MR. PARRISH: I think it's Rochester Hospital is the central point right now.

DR. SHAH: Can you think of any other drug we are asking BLS to draw?

SPEAKER: The Narcan.

DR. SHAH: So I might save on product material cost, but lose on the training cost and QA cost and all that stuff.

MR. PARRISH: The $55.00 cost incorporates the training package with it.

DR. LARSEN: So the actual syringes have -- there is the expiration date on the syringes and expiration date on the drug.

DR. SHAH: How would the syringe --

MR. PARRISH: The syringe in the kit doesn't have expiration date.

DR. LARSEN: It should. If you look at every syringe we use on ambulances or in the hospital they all have expiration dates.

MR. LAMARCA: I think the kits were made so --

DR. LARSEN: The drug was the determining factor --

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(Everyone is speaking at once.)

DR. BENNEK: I think the syringe being described where you had a pediatrics dose and adult dose and you can't give anything -- if you had an ordinary syringe and you had to draw it up, that was the major concern with that option because it's a very big chance to make a mistake and that's a bad mistake. But if you have syringes designed to limit what you give to pediatric dose or adult dose, it limits the risk involved. I think it's an enormous step forward. And that was the only concern with that program. And I would -- I agree my squads --

(The speaker cannot be heard.)

DR. LARSEN: Speak louder, the air-conditioner is on.

DR. BENNEK: My squads complain bitterly about the cost of the Epipen. They feel they are getting ripped off. The biggest concern I had is with regard to the mistakes in dosing. But with a syringe designed to give pediatrics or adult, it's limited and by limiting those mistakes that addresses the

biggest concern. I suggest we go ahead and approve this.

MR. LAMARCA: I just don't know if this program is dependant upon securing the production of those syringe packets -- for lack of a better term -- and what happens when they run out? Because there has been front money for that so it's entirely possible when the kits are done they might be back to regular syringe and drawing it up. I think that was the concern. I think Dr. Dailey made us feel more comfortable it's going to be premarked, but if it's not mandatory and always in supply you will have to consider that you will have basic providers that will have to draw from a syringe up from a one to one thousand vial.

DR. VOHRA: We are not talking about -- there is a lot of opportunity for error. It maybe premarked, but it's the same syringe. You could still draw above for pediatric patients. Is it worthwhile even if it's a little more money -- patient safety, is it worth the money? I don't think so. There

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are 12 cases --

MR. LAMARCA: I think that's the issue --

DR. LARSEN: I'm quickly looking, but I thought my interpretation was it had to be used as a prepackaged kit.

MR. HUGHES: During the pilot program it does, but after that if it proves to be a viable solution it would be changed. At this point in time if you used a kit --

(Everyone is speaking at once.)

MR. HUGHES: If you participate in the pilot project you have to use their kit. The way it comes in it has the expiration dates on the outside and has to follow the directions in the kit. And the individual agencies will be trained by the physicians that are part of the group.

MR. VIOLANTE: Since this is only a pilot project we are only covering for the pilot time, correct?

MR. HUGHES: Correct.

MR. VIOLANTE: If it didn't go through and was found non efficacious and not

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possible, it would be scrapped.

MR. HUGHES: Yes. And the pilot will extend as long as the life of the medication that is in the kits, so it could go 14, 15 months, 18 months.

MR. VIOLANTE: I would like to suggest we go through if it's only a pilot, see what the results are and be a part of moving EMS forward in some way.

DR. LARSEN: Well, you know, having talked to Mike Dailey briefly about this, I think that if this pilot is a success it will go forward identical to the way it's setup. Because if it doesn't, it's a different story so it's going to -- you know, from -- that's the idea so -- so then the question is, are we going to pay for the kits and that kind of thing? But if it's successful it will not go forward and not be extended out there unless it goes pretty identical to this unless there are intimate corrections that are made within the guidelines of the program. So I think we can feel it's not just going to -- yeah, this works. I know you can draw it up on your own

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with your own syringes, that's not going to happen. This is what we tested, so we can't come up with something new and release it out there. Okay --

MR. HUGHES: We need to vote on whether or not we want to let our agencies participate in the pilot from a REMAC point of view.

DR. LARSEN: So I need a proposal to support the check and inject pilot program and that any agency that wishes to proceed in the Hudson Valley can go ahead with this.

Do I have a motion?

DR. BENNEK: I'll move.

DR. LARSEN: Second?

DR. MAO: Second.

DR. LARSEN: And a vote. All in favor?

ALL: Aye.

DR. LARSEN: All opposed? Abstain?

Okay, do you have a -- would you like to voice why your --

THE COURT REPORTER: Wait, there was no verbal -- I had no verbal opposition. Did you just raise your hand? Because I can't

get that on the record so you are nowhere on the record as opposed to this --

DR. VOHRA: Opposed.

DR. LARSEN: Do you wish to --

DR. VOHRA: I said no because I would like to see first, that's why. I would like to see what I'm voting on before I vote.

DR. LARSEN: So it does pass and we move ahead and we do have a quorum.

So now -- oh, Mr. Crutcher, PAD, Epipen, albuterol?

MR. CRUTCHER: Applications for adjuncts keep coming in at a steady rate, seeing an increase with the summer camps being open with new PAD applications, updated PAD applications, and Epipen applications. The rest of the adjuncts, I-N Narcan remains fairly steady. We have in the last month and a half eight administrations with the reversals by BLS that have been reported to us. And the program continues, we did get renewed for the grant for the next year. So we will continue to support the training and support agencies with Narcan.

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DR. LARSEN: Are there any other reports of internasal? What is happening out there in rest of the world with people using internasal or not, anything? It seems to be the rage out there so --

DR. BENNEK: We had -- we had a number of reversals, at Sharon Hospital as well as Connecticut and New York, mostly on Connecticut side being used, a number by BLS successful reversals. So it's getting used, it's being, I think, well-used and appropriately used. And I think it's potentially life saving and I think people are coming in --

(The speaker cannot be heard.)

DR. LARSEN: And are you seeing this by police agencies?

DR. BENNEK: By our BLS squads and any using it for appropriate indication as well as depression. But by the time the patients come in they are looking good and talking to us so it seems to have been very successful as far as I'm concerned.

DR. LARSEN: Any other comments?

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DR. ARSHAD: I think --

MR. MURPHY: We have the program with the Rockland County Police agencies. We have had 17 reversals since the inception of the program -- and we've actually 18 administrations, 17 reversals. One person was unfortunately not very well beforehand, but I think all in all with the police being first on the scene they are administering appropriately and actually saving 17 lives.

DR. ARSHAD: So in an analysis of the biostatistics epidemiology, this is going to be a really bad summer of heroin overdose. We see as the weather is warming up, the use is definitely increasing.

I know we bantered about the ethics of RNAs during the post Narcan revival and primarily the literature is from the study out of --

(The speaker cannot be heard.)

DR. ARSHAD: -- which looked at the death registry post Narcan administration and they find no patients, zero patients that receive a Narcan revival subsequently died

within the next 72 hours. Nevertheless, we are finding many patients receiving prehospital Narcan revivals by BLS or police will subsequently require a repeat dose or second administration by ALS. So I've got an IRB approval to analyze vital signs and comorbidities and the type of ingestion to see if we can determine a clinical prediction tool for patients who are likely to relapse from -- so summer, watch out. It's going to be a bad summer, so keep your eyes on it.

DR. LARSEN: Moving onto open forum. First thing we actually have on there is a review of the Valhalla train wreck.

Dr. Berkowitz?

DR. BERKOWITZ: I thought we had talked about this. I feel like I talked about it so much.

So did we talk about it at the Hudson Valley REMAC? No? So looking back at the accident and what we are doing, I'll just tell you what we are doing to change the mass casualty plan from what happened --

DR. LARSEN: Why don't you give -- sorry

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to interrupt -- give -- not everyone may know what happened.

DR. BERKOWITZ: So in terms of -- to make it short, you know, the accident did involve the MTA train hitting a car and one of the rails actually going into the first car and a few of the cars derailed, but it wasn't like the mass derailment they had in Baltimore. So it's a very different type of accident then you would expect with a train accident. I think it's kind of an -- I guess all accidents are freakish, but this was freakish in its own way.

There was a multi-jurisdictional response between fire, EMS, MetroNorth. And there was, you know, 12 patients, plus a few others from the car accident initially that came to the hospital -- that came to our hospital.

In terms of the communication, which is the biggest issue that we always see in these events, there was very poor communication, there was the usual kind of, what can you take? And then that was kind of, this is

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what we are seeing, a total number of how many patients maybe. A lot of patients were moved to a local -- a lot of passengers were moved to a local gym and -- because of the cold weather and there was a lot of kind of chatter. So there was chatter going on about buses being deployed, possibly emergency response multi-passenger bus, so a lot of chatter. The hospital -- our hospital had a pretty significant ramp up and we cleared most of the ER and by the time the patients were arriving had several teams available. And by the time that the incident was kind of fully underway had, you know, several -- 10 OR's at least that were kind of ready to go. So the hospital response was pretty good, but there was some communication issues that I think that I am trying to address as much as possible.

The -- there was really a kind of a -- there was no real response -- so at the scene obviously it's chaotic and a lot of things going on. They didn't use any kind of triage tags, which was concerning. Now, all the

patients came to us so that makes it easier, but had this been a disaster where patients were being distributed across several institutions, that would have been a huge tracking issue --

DR. SHAH: Was there an incident commander?

DR. BERKOWITZ: There was an incident commander, but there wasn't really a transport section going on who would kind of be pushing that end of it. There was the fire incident commander, that was one issue that was -- on our side there was a lot of information coming into the hospital. And I think with everyone having a cell phone now, having access to information, you know, if there is a mass causality in your area you are going to find that the amount of information you receive is much more than you would have received 10 years ago. So different people at the hospital receiving different calls from different people, their friends, volunteer firefighter friends, people that we knew in EMS. There is a lot

of information there, where it used to be that you kind of get what you get, now it's like it was overflowing.

And so one of the things we would change with our plan is we have a defined person -- we are going to actually designate someone to really be in charge of receiving all incoming information and keep track of it. So that if you have one nurse who takes an ambulance call, they pass it along to someone else and then another nurse or someone else takes another ambulance call and all of a sudden you quickly lose track of all the information coming in, aside from the ancillary information I'm talking about. I think that's a good beginning model. I think that as technology continues to develop the amount of communication during a disaster will increase and I think we should always be prepared for more and more information coming in more rapidly during a disaster. So whatever your plans are, I would expect that to be a continuing issue going forward.

I've tried to raise the issue with the

protocol committee at REMO, to suggest that maybe the protocols should provide more guidance to crews arriving on screen. There are defined -- it's well known what is supposed to happen on the scenes in terms of EMS and there is kind of a difference of opinion really. You know, the EMS folks tend to say, well, we know what we are supposed to do on a scene, what we are trained to do. And the docs say, every time there is a disaster we have these communication issues. I think that is going to -- kind of be part and parcel of the problem.

I think that there also was very limited communication from the scene -- you know, once we get the initial notification there was very limited notification from a centralized standpoint to the hospital. That was concerning as well, we are working on improving that. There was a lot of communication, but it was fragmented. And that's why I think the answer from my perspective is to say we should be trying to manage the communication on our end more

because we can't ensure what will happen on the outside end. And I think regardless it's going to increase.

There was a fair amount of difference of opinion of the amount of information that should be sent to us. I was just on a call a week ago discussing some disaster planning in the Region and I was told that under some plans in our Region that ambulances were told to -- they don't even need to call in if they are bringing a patient to a hospital in a disaster. Whereas other people said that they are supposed to call in. So there is a fair amount of confusion on what is supposed to happen even in those areas. So I think that the big thing is, of course, communication.

And I think I would recommend next time you look at your disaster plans you look at how you are going to manage the communication from outside to inside because that was a huge issue for us. Although I think that our response was phenomenal, but we were also very lucky in the sense if it was like the

accident in Baltimore it would have been a much bigger issue. And the fact that the patients that arrived were -- some were primarily trauma, some were primarily burn, meant that you could actually kind of have -- you had more doctors to take care of them in the sense of the teams taking care of them. If you had a single type of injury, like toxic exposure, where every patient needed kind of the same treatment and set of doctors it would be much harder to respond based on resources.

DR. PAPISH: You touched on the transport officer, there wasn't one at the scene? That's kind of a recurring theme at all of the big MCIs in the region. Did they in the hot wash after talk about that at all, did everybody go to Westchester, or --

DR. LARSEN: A couple things, just for people, the accident occurred actually, as you see, Valhalla. Valhalla is the home of Westchester Medical Center so it happened within a mile or two of the hospital. And if it had been one person injured there they

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would have automatically gone to Westchester, so everyone went to Westchester. And my hospital, White Plains, would have been the second closest and we got no one. So there was no -- and there probably wasn't a need to fan them out because it was a kind of freak accident. You know, if it was a train hitting a car and, you know, they weren't going super fast and normally the driver of the car would have just been killed, but somehow it flipped up this third rail, which then pierced the first car. So it wasn't, like John said, it wasn't -- but there -- well, when there are 675 patients -- passengers on that train, so it had every capability being a really mass incident, it was an evening commuter train coming back. So the unfortunate thing is that although the county has fairly sophisticated communications equipment and stuff to put in a full incident command with good communications, that really wasn't ramped up. And so we explored some of the reasons why. You know, they need to be technically asked

to do that, okay? They can't impose themselves, it's just like home rule kind of stuff. And so they were not asked to bring in their -- you know, bring in the heavy duty gear. They could have rolled that stuff out and it would have been there pretty quickly because they weren't very far from --

DR. PAPISH: You are talking about 60 Control?

DR. LARSEN: Yeah, 60 Control, which also sits right near the medical center. So it wasn't like they had to take the equipment a long distance, so it just didn't happen.

DR. PAPISH: Even without bringing in the big MCI guns anytime a certain volume of patients, once you have above 10, 15 patients, you would think that somebody should be thinking about, you know, maybe I should disseminate these patients a little. Not saying Westchester can't handle them, I'm just saying historically in every MCI I heard about we always have this issue and so --

DR. SHAH: The problem isn't knowing the 10, it's not knowing how many we are getting.

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DR. BERKOWITZ: Exactly. So I mean, 100 percent we were very more worried about the patients we didn't have than the ones we had. So the surgeons were worried because we had OR's open, but they don't want to send patients who needed an urgent surgery to surgery until we knew that there weren't any emergent. And we know that usually the patients that arrive -- that frequently the first patients that arrive are not the sickest. And in this case because it was a freak accident and because the rail skewered and did what it did to the first car, the sickest showed up first.

This is why I brought it up to the collaborative protocols saying, why don't we provide some guidance on what should happen? Someone should really, whoever arrives on scene should kind of essentially take themselves out of service and start helping with transport decisions. I do think that we should advocate that there be a limit -- that the number of patients above this number, they should use their mass casualty plan.

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DR. SHAH: Two comments. I think you should do it anyway for the practice --

DR. BERKOWITZ: Yeah, that's what I'm saying --

DR. SHAH: Can the hospital activate the plan?

DR. LARSEN: Can the hospital?

DR. SHAH: Yeah.

DR. LARSEN: No, the hospital cannot. They can request it. I mean, we have the -- we could immediately go on -- in Westchester we have the -- what is it called? The interoperative phone system, which basically we can pickup the phone and call every hospital in the Westchester system and say -- you know, 60 Control would automatically come on to that and we could ask for that. And I think if a hospital were to do that, I think 60 would probably be responsive to it. You know, that's what I'm hoping. In other words, we are being overwhelmed, you know, I think you need to go with your county plan.

DR. MAO: There was a little rerun through at Good Sam as well --

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(The speaker cannot be heard.)

DR. MAO: -- something small to Hurricane Sandy, basically you take a sport utility and minivan, it involves multiple agencies and they are not used to working together and this is where communication is breaking down. I think this is something that hospitals have to take the lead and teach the local corps they are involved with about the mini MCI. The crews are good, they pickup a patient and run, they are used to going to your particular building. But not used to, say, if that crew that is taking it, the local corps, what do you have when you have one sport utility, six or seven patients down, what do you do? It's very small, may not be enough time for the county or -- whichever county you are in to bring in the awesome vehicles. It's very fast, quick, short, the mini MCI. I think we have to take it upon ourselves to --

MR. MURPHY: I agree with Dr. Mao and Dr. Berkowitz to an extent. I was not at the hot wash for this particular incident. This

sounds like there was some particular inconsistencies in how command was established and how the officers under command were delegated. As one who teaches this on a routine basis, an MCI will disintegrate in the first 10 minutes if it's not established correctly. And it sounds like this may have been the case here.

I do not think protocol is the appropriate way to handle this particular instance moving forward. I think it's an ICS EMS command training program that needs to be reiterated to the folks on how to deal with this. You folks are the experts in the emergency room, we happen to be the experts out in the field. I don't think that at this particular instant there was enough expertise at this particular incident. So I don't think we should take this one and try and do a wholesale retooling of stuff that already exists. I think that in our CMEs that Good Sam does that perhaps bringing in incident command folks with experience and just reiterate to the corps, you know, you need to

establish unified command, you need to establish a transport officer.

With regard to the differences in communications that you had, that was contrary to what should be done. The transport officer is the person that is supposed to communicate directly with the hospitals. So to -- the ambulances do not give individual reports unless there is a significant demise of the patient en route so there is not all this communication that comes in. I think from what I heard today the best thing you did was select one point of contact in the hospital. If each hospital emergency department has one point of contact and that's made known to the corps and to the management folks in the field, they will know that their transport officer needs to contact this individual and relay information to this individual and this individual only and that will decrease a lot of the confusion that you may have experienced. I think we have a tool that is already in place, we just need to go out to all the training folks and all the

agencies and just retool their people on this how it's supposed to be done. And from the mini MCI to the large MCI, the whole thing is designed so it can evolve and we get into the idea of, you know, at certain points in time -- ten is a good number -- you start thinking about bring your patients to other hospitals, et cetera.

So I don't think there should be a significant retooling from this body. I think the stuff already exists, this is probably a classic example of where ICS failed.

DR. BERKOWITZ: Do you think that sending a lower limit -- setting a limit with a patient number greater than some number, that you should use ICS? Just putting it out there and actually forcing --

MR. MURPHY: Yeah, I mean, it's there. There the definition we teach people is the classic number is around five to six, that's the number that circulates in any of the training programs. The other -- that number may not apply to an individual corp in a

rural area, two people may overwhelm their facility and organization. Therefore, it's now an MCI to them. Classically you get into that range of six, it kind of triggers that this is something that needs to start establishing these command officers, the transport officer, the triage officer, staging officer, those are the three that have to be done immediately. And I think those were not done quickly enough and anybody that's been on MCI understands that if the person in command does not do this within the first 10 minutes the whole thing gets away from them.

DR. BERKOWITZ: Just to follow-up, I think that the problem that I have seen in our region is that there is a soft number and so it's open to interpretation. So there are a lot of -- there are a lot of potential incidents that would be good training examples and good practice that aren't utilized for whatever reason because it's soft and they know the hospital will deal with it and it's no problem. So I agree with

you, there are some areas where two or three really sick patients on its own is an MCI, but at the same time if it reaches higher than some number -- kind of what Dennis was saying is true -- you should go into that mode.

And one of the other changes I made is, rather than focusing on full drill -- we have to do drills -- but we are focusing on a lot of tabletops, where we can just go through the motions, which you can certainly do -- we can do it with five patients quick and it won't slow you down. You know, you just do it and do the process, in and out in five, ten minutes. If you just kind of say, how would this play out? What would the plan be? Who would do this role? How would it be done? And go through it. So I think after seeing a couple of drills and seeing this we are moving to drills, plus more tabletops where it will be a 10 minute tabletop in the ED where everyone will take their role. You make a plan. Say, what would be doable right now? And 10 minutes later you are done,

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coffee for everyone.

DR. LARSEN: Michael?

MR. BENENATI: The comment I have is, certainly we have a very fragmented system in New York State with multi-disciplines covering the same jurisdiction, which causes a lot of problems and you need to identify how do you fix it moving forward. And some of the stuff has already been thrown out, but it needs to be a larger scale approach. So maybe I train certain key people from each agency in your county to be in response team, ready to respond and coordinate these things. The people on the street providing EMS every single day don't always prepare for implementing that system at that stage because we don't do it every day. We don't behave that way every single day. Our systems are not setup that way and our systems are fragmented and until we start behaving with incident command at every single incident and realizing that even --

(The speaker cannot be heard.)

MR. BENENATI: -- if we don't put that

behavior into our providers we are never going to be able to do that incident that happens once every 10 years. And to me that's the biggest challenge. So I'm offering it so that we put this into every single event. We do even a fire standby -- you know, when we show up -- when our crews show up at fire standby with maybe one ambulance, maybe one person sits in the ambulance with their cup of coffee, maybe one gets out, they are not ready to go if somebody goes down. We don't respond with three vehicles, one that is a go team, one that is a rehab team and one that is the transport team. We just -- we are just not doing that. Until we begin behaving like that every single day we won't be able to handle the big ones. And we are talking about the same thing time and time again.

DR. MAO: It sounds like it's based on the CE program, because you can't test these things. You have lectures for courses, continue lecturing, it's part of ongoing education process. And, again, as EMS this

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is a continuing process.

MR. BENENATI: Absolutely, it is. And what we have to understand too is when we teach MCI, people like to retain that category of incident commander. But when you take those responsibilities -- and what I do is I put them in a ball -- that list way greatly exceeds the ball, maybe start splitting it up in different sections and then they see that they can manage it better. But people don't understand all the complexities of being incident commander and breaking it up into your branches and sections.

DR. PAPISH: So to summarize kind of what everybody is saying, I agree we don't need to retool what exists. EMS already has a framework that exists for handling even mini MCI. Perhaps going forward maybe we should push, for example, when you do have an absolute number of six -- or we can arbitrarily set it -- we should deliberately emphasize the need to make it an MCI all the time. We have car accidents with six

patients, no one announces it's an MCI and takes care of the issue. But the more we do that and more we make a case, this is an MCI and we are going to have somebody diligently decide where to transport the patients, when we do have 10 patients, or 12 patients, or 15 patients we are going to run efficiently -- which we haven't so far. I think the biggest thing going forward is just to push this. I don't know if there is a way to disseminate it to everybody --

(Everyone is speaking at once.)

DR. PAPISH: I think providers on the scene don't want to make a big deal out of something if they feel they can get the patients to the hospital quick. But this is -- by doing it, every time you do it you get good.

MR. BENENATI: It's a behavioral change different from the way we are doing it.

MR. VIOLANTE: There is two other facets you alluded to. One, that's home rule issue, which can have its pros and usually has many cons to it as a New York State thing. And

there is other than just EMS agencies involved that are making decisions that EMS has to follow, and that's fire departments and police departments that have to work as part of a unified command. So I suggest those agencies also be involved and come and participate and realize that that may change every year, if not every six months, as to who is actually participating because of their roles in the agency and because of home rule, those are the guys who are making decisions at the village, town level as well.

DR. PAPISH: But they are not usually making a transport decision destination.

MR. VIOLANTE: They are making above the transport as to who is doing what, so they may not even delegate a transport officer. They may say, take these people to the hospital, we have a bigger incident.

MR. LAMARCA: I think that usually the purview for this is in the individual counties. Actually, that's where the disaster plans are created, that's where they have to be modified, that's where the

training should go. Yes, everybody in the State of New York has to take incident command and be certified, it doesn't mean they have mastered it certainly. I do think that largely because of where we are we have a fragmented EMS system and the more times you have multiple agencies responding that don't often work on the scene together, the more likely it is not going to go well unless they are brought in and have this training at county level. Again, trying to say we want these command officers, let's go, they are trained, but the first in usually cease control and start to dictate who will be what. It gets into an issue of nobody is in control. I'm going to do -- without giving a hard number I think it's kind of difficult to figure out what the hard number will be. I know normally what we do, but I think we have to go back to the basic premise of if the amount of casualties overwhelms the initial responders they are supposed to implement some form of MCI disaster plan to get additional resources and bring in the

elements of command.

DR. ARSHAD: Just a couple of things, I'm so excited how passionate everyone is on MCI and disaster preparedness. One aspect we should bring back to the hospitals as MAC physicians is awareness of the hospital incident command system, or the HIC system. And this is something not regularly exercised and not regularly drilled within the hospitals themselves. So we talk a lot about the prehospital side and disaster triage, but it's something we have to do interim as well, whether active shooter, whether in preparation for multi-casualty inbound to ED. And we did a CME this past Thursday and as part of call review we organically reviewed a mini MCI where a school bus rolled over, incident command was established, triage tag system was very quickly utilized, green tags separated. There was one patient that required rescue and triaged a red TAG, hospital incident command was activated and additional surgeons were present in the ED by the time of patient arrival. And we drilled

this by simulating a chlorine plant explosion this past October at Mid Hudson where we got all hospital administrators ICS 100 and 200 certified. So, in other words, no joking around, everyone needs to --

(The speaker cannot be heard.)

DR. ARSHAD: And then we simulated MCI with real patients and members of the emergency department. And I would also advocate that every physician on this Board get at a minimum 100, 200, 700 and 800, which are all available for free on-line by FEMA. And both in Westchester and in Dutchess County we had 300 and 400 courses. So please push that training within the hospitals and actually practice and examine your hospital incident command system.

And in regards to training, it certainly comes down to drills and actively drilling disaster triage. It's something we don't do every day and, unfortunately, the MetroNorth derailments are becoming more frequent. I just published a paper in prehospital and disaster management regarding the MetroNorth

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derailment in the North Bronx, where we used the FDNY --

(The speaker cannot be heard.)

DR. ARSHAD: -- we generated twelve patients and we had additional orange tags, four black tags and eighteen red tags. And that was a system actively drilled, the first prehospital care provider on scene was, in fact, an FDNY medical director and he was like, I'm not going to the sickest patients, goes into his pocket, pulls out a stack of triage tags and got to work. And so this is something we certainly need to drill and I know that in Dutchess County we just planned a large scale MCI preparedness day and this is something we continue to push and advocate for.

And just if I may quickly invite everyone, this coming Friday we are doing a --

(The speaker cannot be heard.)

DR. ARSHAD: -- in Wappingers Falls and it's going to be on marathon medicine. The Commissioner of Health will be attending for

Dutchess County and we are going to be doing a MCI on mass gathering, multiple red tags, patient after patient this Friday. I would love to have you participate and certainly extend an invitation to your folks.

SPEAKER: Also on that note, vital signs of preconference is going to be out there on the start triage, the field triage and the decision to go to the right hospital with incident command.

DR. LARSEN: So anything more on this issue?

Yeah, I think there is a number of -- certainly opportunities to improve. And there is also a certain learning curve of when you are the first person on the scene then in some way you are the -- first you know, small group, you are the incident commander, and then being able to sort of know when to pass that off to higher and higher levels as more resources come in. So that has to be an ongoing discussion.

You know, it happens right there in the field, okay? So who is now stepping into

this and then as you get more people making those assignments that we talked about for all the different components of ICS. I think practice certainly helps with this, but there are certainly a lot of issues involved with it.

Let's do -- we have one more thing, the interfacility transport sheet. That's also Dr. Berkowitz.

DR. BERKOWITZ: One of the things I want to put on this, I don't know if you have seen it, it went to RTAC. One of the things I think I put on this version -- is the blood products. So I want to take us back to blood products because I do believe that blood saves lives. And I feel like we short-shifted the blood in honor of long board mobilization. I know it's very important to you -- not to give long board the short -- so would anyone be against some sort of advisory or statement that said we believe that interfacility administration of blood saves lives? I know of cases from our institution where that is definitely the

case. Just so that we make it sure, I think that -- I think that I would argue -- again, I'm sorry -- I would argue that not giving -- that blood is potentially more of an issue than is long boards in terms of the inability to give blood is a bigger issue than the ability to overboard.

So I don't know, do people have thoughts about some sort of statement we can make that hopefully will coerce the Commissioner to sign?

DR. LARSEN: I don't think that needs comparison. You know, it's not -- I think it's a very important issue and we have to --

DR. BERKOWITZ: Because I would like to put a form out when we can give blood because the most important order that will be given in transferring a trauma patient will be the order to continue infusing blood --

DR. WILSON: Blood products.

DR. BERKOWITZ: Yeah. The rest is important, but that's the big thing. So I guess I'm proposing a statement or advisory that would say that we believe that the

ability to continue infusing blood in the transportation of interfacility patients is critical to patient outcome and patient safety.

DR. ARSHAD: May I go on the record as saying I completely support your advocacy of this topic. And we have brand new literature to show how important this is. The proper trial was released probably two and a half months ago, large military study were the physicians or resuscitationists (sic) completely changed our mantra or philosophy to resuscitating patients in hemorraghic shock and it's completely turned it on its head. Crystalloids have been shown harmful if used at the first resuscitation strategy --

(The speaker cannot be heard.)

DR. ARSHAD: -- platelets pack, RBC and continue with aggressive transfusion protocols. And the data on this and the safety on this, more importantly, on the prehospital aspect side is now overwhelming. So we are at a point we certainly should

embrace the evidence and push for the highest quality.

MR. LAMARCA: I think we know who is going to write the letter.

DR. BERKOWITZ: I'll write the letter, that's fine.

DR. SHAH: Loud and slow.

DR. BERKOWITZ: No. I type hard and fast.

DR. LARSEN: Okay, so once the letter happens then where are we at?

DR. BERKOWITZ: I mean, can we -- if it captures those sentiments can we forward it along to the Commissioner saying that the Hudson Valley REMAC believes that this is a -- yada, yada, yada, yada. We can send it out to the group by e-mail.

DR. LARSEN: I think it has to -- somehow it has to come back to this group. It doesn't necessarily have to be at a meeting, but we need to establish a mechanism to come back to this group, at least before it goes out so that we know what we are assigning essentially.

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MR. LAMARCA: You may want to make contact with Dr. Haddock because he was directed to send the letter -- he may have had interaction with the Commissioner already. You might want to check that first, we may have some movement already it.

DR. BERKOWITZ: Other than that on this form the goal of this would be -- we don't -- we do not have interfacility transport protocols and so this would be a standardized form for giving transport orders to the unit providing the transport.

Has everyone had a chance to look at it? I think I've gotten my last round of comments, but I'm still open to more. My goal is to roll it out at the same time as we get blood, so I don't have to have two forms circulating around.

And the other part of this -- I mean aside from that it's kind -- the other question I had is in terms of operationalizing this, would it be better if this is something that -- essentially the unit asked the doctor to sign, or that the

hospital had and then gave to the unit? Because right now, just so we know, when I look at these trauma transfers and the transport to be done, there is no -- there is not really much documentation of what is actually the physician orders, which is not really good for the patient, nor for the receiving hospital -- it's not good for anyone. So my question is how should I operationalize this?

DR. SHAH: The unit should give it --

DR. BERKOWITZ: The unit should say hey, doc, do you mind filling out these orders for me? That's what I think too, does anyone have any --

MR. PARRISH: I think the hospital should have it as part of the --

MR. LAMARCA: Unit, as in ambulance you are saying?

DR. BERKOWITZ: Yeah.

MR. LAMARCA: I would think that it would be the hospital. It has to be in the ER. They really -- sometimes it's time critical, they don't want to stop and do

paperwork. When we are coming in they should already have it attached to the PCS and sign off and we have a full of doctor's orders.

DR. BENNEK: In other words, to get a document like this it has to go through forms --

(Everyone is speaking at once.)

DR. BERKOWITZ: That's a problem so they are --

(Everyone is speaking at once.)

DR. BERKOWITZ: -- every hospital forms committee will have to look at it.

DR. PAPISH: Right now if a transport crew shows up they have a form that we sign, you know, which has the orders on it.

MR. LAMARCA: It's probably the PCS and on the back we can write orders. But I think in the region -- we have sent out forms when we do intubation, things like that. I think we have capacity to send out something underneath the region for the ER's for completing this form. I'm not all that sure, but --

DR. PAPISH: If the hospital ends up

getting involved then it's problematic because every -- their ICU guy will be like, wait a minute.

DR. BENNEK: I think your model would work, that we have the forms that come from the area EMS providers, that they sit in the ED, but they don't have to be approved. So this skips that process, but it would be an EMS document, but it would sit in the ED as always available that way it gets filled out ahead of time.

DR. BERKOWITZ: I suspect that most of this would be done in concert to the actual communication so you are not going to just hand them this and say good luck, buddy.

MR. PARRISH: That's what happens now.

DR. BERKOWITZ: Well, right now if it happens it's just good luck.

So I think either model is possibly tenable. I would like to know from people what they think would happen in their hospital if we approve this form and then we send it to the hospitals and say, can you stock this in the ER to give to the

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transporting agency -- the transporting unit for orders en route? Whether there would be issues in your hospital.

DR. WILSON: I think it would be redundant in some hospitals because -- we do have that already placed in our hospital so we fill out three forms for every transfer and sometimes four for psychiatric. So for our hospital to have to fill out an additional form that is already on another form, because we do do orders on one of the transport forms for Northern Dutchess Paramedics. So maybe in lieu of that form we could consider that. That's the only problem I see, it's just another form really. It's already being done on a form -- maybe not every hospital, but in ours it is.

DR. BERKOWITZ: So I think that what we come back to is -- I think you are in the minority of actually having written orders for transfers.

DR. PAPISH: Rockland Mobile Care has a form too. The question is -- you are saying specifically for trauma patients --

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DR. BERKOWITZ: For trauma --

DR. PAPISH: -- we would use this in lieu of it as long as the agency -- like does Rockland Mobile Care have a problem if we filled this out?

MR. MURPHY: We are -- we wouldn't have a problem if you give it to us. I think you guys have a problem internally filling out another form. And it's a trauma patient and now we have to fill out this form and plus still fill out the PCS form because the form is married to CMS and married to -- so the PCS form has to be filled out, the back of that is where the orders are. So I can see this saying on a trauma patient, PCR and the back of the patient PCS would be see trauma form and fill out the trauma form and make sure they are married together when we picked up the patient. Operationally I think that would be okay. I think it's an additional burden on the sending folks, but that's up to you guys. You give us three pieces of paper or four, it doesn't matter to us.

SPEAKER: Could you produce one form

with all types of transportation regionally that will be approved interfacility transport form like in the olden days?

DR. BERKOWITZ: I think that's not a bad idea as well, if everyone would agree to it. I mean, at some point in time you just bite the bullet and agree on making interfacility transport protocols. It's going to -- it's kind of a patch for that to some extent.

DR. PAPISH: This has been four years we have been debating that --

SPEAKER: We used to have it -- not a protocol, the form.

DR. PAPISH: Why was the form suddenly abandoned? There was a reason, I don't remember why, it was such a long time --

DR. MAO: One, we have to make it digitized, medical legal corporate compliance is going to scream if they can't get it and QA QI, if it's not digital --

(The speaker cannot be heard.)

DR. MAO: -- maybe like one form. We don't have to reinvent the wheel and it will cut down on the paperwork, we are always

adding more and more papers.

MR. LAMARCA: I think what we have to realize is, especially about the trauma transfer, usually -- in our case it's a yellow form and PCS and has medical orders on the back, that goes for how many other types of emergency transfer? So to get one form to do it all would be kind of difficult. I agree that it has been mentioned before. If this was standard and instead of you writing the orders on the back of my order sheet, say, see trauma transfer form, that's it, you fill out the front and back. And each of us use a different form somewhat because of necessity or --

DR. BERKOWITZ: The problem is that we need to -- we should have more standard care for interfacility transfers, especially for trauma, but all the patients it should be a little more standardized. This could be this form, it could be protocols. The question is what works and we can kind of take it from there. I have no problem tossing this out per se. I rarely see charts from

interhospital that have orders in the scanned paperwork. So that might be a process -- it might be a symptom of other processes. They might exist in another galaxy, but -- so you know, I'm open to hearing how we can make it happen. I think having one form for all interfacility transfers -- it might be a much larger form, at the same time if everyone would agree and standardize it, it's worthwhile. Whatever we can do to reduce variation is good for our patients.

MR. MURPHY: I just have a question as to the origin of the form, why it occurred? Because we seem to -- just speaking for my agency, we have a physician order form. We get a patient, the physician writes the orders and we leave with orders in hand. Our crews don't leave without orders in hand and those orders are written down. So I question the origin of this form relative to -- you are saying on the other hand, you know, we see sheets that have no orders and crews are essentially leaving without orders. This is what I'm getting.

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DR. BERKOWITZ: Yes. So that was from a conversation that happened at the RTAC where several trauma surgeons said they felt like there was -- they weren't comfortable with the communication and possibly because they didn't fill the forms out so to speak. But that a trauma surgeon at -- another surgeon sending to our hospital wasn't comfortable with the orders that were being given, or the ability to give orders, or anything that was going on en route. So that was what kind -- spurred the creation of the form. But, you know, I could be wrong, it could be the system works fine and that is just a bunch of cranky trauma surgeons.

MR. LAMARCA: I believe maybe if the issue is we fill out the yellow form, we retain that, you don't get it at the end of the transport, so unless the hospital that is transporting wrote in their notes or paperwork you would never see what the transfer physician ordered. This is not something we make copies of usually for the receiving hospital. So it could have been

ordered and it's probably in our files and maybe the trauma surgeon will never see it because it was never duplicated inside the hospital.

DR. BERKOWITZ: So the better solution might be to take something like this and do what we need to do anyhow and have IT protocols -- which is a longer process, but this has a long enough process anyhow. Because from my experience that -- you know, I still think there is room for improvement on this issue. But, you know, if you -- if I'm hearing from you guys you think it works okay so --

MR. LAMARCA: On the record -- or off the record -- but I always find it desirable if you have a menu, choices here that someone -- somebody following when we arrive and that these things were done it's usually beneficial. My form is a nice open form, write what you want, but if you could give me some suggestions on what you probably should be using for that trauma patient, it would be appreciated.

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MR. MURPHY: I think that's where we get the idea of protocols/guidelines, if you guys as a body were to develop interfacility protocol/guidelines and a template that a sending physician would be able to use to write those orders, we would incorporate those documents. I think that's probably where we should be headed.

DR. PAPISH: Is there a subcommittee on this? That's where it's going to start, is it protocol committee or --

MR. LAMARCA: I'm going to suggest we send it back to protocol committee. Earlier we were reviewing a lot of the protocols throughout the 18 different regions, some of them do have interfacility transfer protocols, some pros and cons to it. But perhaps we go back to the drawing board and take a look at some of the protocols already in existence in other regions, see what they look like for interfacility transfers and should we develop an additional set of protocols that just deal with interfacility transfers.

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DR. BENNEK: Just -- an individual patient may need specific orders so the protocol may give you general guidelines about how to handle things, but we probably need something of this sort for specific orders on that specific patient --

(The speaker cannot be heard.)

DR. BENNEK: And I was going to suggest having a packet, for example, having transport -- the stuff you need, have a medical transfer form and trauma transfer form and try and put it in one packet. And the truth is, I find these sorts of things helpful when I'm writing orders. I'm in a hurry and I don't remember every detail, this is particular, it helps you remember details.

DR. BERKOWITZ: That was the original idea, but it seems to be butting into existing processes. Certainly if we came up with protocols we could capture those protocols in probably a double-sided sheet for everyone -- which I'm okay with that as well. I just want to do something that makes it a little bit more -- reducing the

variability --

DR. VOHRA: When you talk about transfers to facilities, even outside of trauma, most of us don't have pediatric care so having dosage amounts written would make it simpler and enhance the patient care going to that bigger facility for patients we don't commonly see. So I think developing a protocol will really really augment the patient care we deliver. I'm on board for helping in anyway I can.

DR. BERKOWITZ: I'll take that under advisement, thank you.

DR. LARSEN: So what is the final --

DR. BERKOWITZ: I think the final is there are a couple things that I'm taking from this discussion. First of all, I think whatever we do should probably take into account for all patients and be more standard across all patients, which is fine. This started as a conversation on RTAC, but ultimately this is the group that really is doing the transfer, this group is much more involved than the RTAC. So I think that's

totally fine with me to do that and I think we should have a discussion about protocols, maybe go to protocol committee. You tell me when the next one is and we can sit down and just discuss and see what we think would be helpful to making this work.

DR. LARSEN: Okay. Good. Anything else under open forum?

MR. HUGHES: You have one more.

One thing that we did not mention from the SEMAC meeting was that there is going to be a new hemorrhage control protocol coming out on the BLS side. And they are going to be changing the way we apply tourniquets, they are rephrasing it to be high and tight on tourniquets. And if the REMAC allows they are going to be able to use skin closure devices, which we had voted on in the past and said yes, we could, so --

MR. LAMARCA: I think they went belly up --

DR. WILSON: You are talking about the scalp, right?

MR. HUGHES: Well, we are talking about

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non tourniquet --

(Everyone is speaking at once.)

MR. HUGHES: Anyway that's going to be in the future, a protocol coming up. That has gone also to the Department of Health to modify so we expect a policy coming out on that shortly.

MR. LAMARCA: I know we are rewriting the medical control plan. We had some discussion about, again, medical control physicians or ED physicians, matter of fact, physicians or physician assistants that are medical control qualified, by signing the PCRs on the patients that we bring in and at the time it was about the number of locums they were using and problems getting them credentials. It seemed to disappear and in the last week we had three or four cases where we had locums involved in refusing to sign. I don't know why they would have been a medical control physician if they are not already credentialed and I don't believe they were. I'm not sure if it's an uptick in the use of locums or -- might want to go back

because it's a pitched balance, no, I'm not signing. And luckily in one or two cases the department director was there and got them to acquiesce, it seemed to pop up again.

DR. LARSEN: I think there is probably an uptick in locums. And the other thing is, I think a lot of them are just not even aware that they are medical control for our EMS system. So they come in and they are just brought in and here you are, you do your thing. The other thing is, it depends also if you have got multiple physicians and a lot of them don't even know to go get a physician stable and employed there and is already a Hudson Valley REMAC medical control physician. So anyway --

DR. ARSHAD: Just a small tack on point, with the advent of ICD 10 there will be specific physician billing codes for on-line medical control, in addition to, as well as community para medicine. So it sort of behooves us to take on-line medical control more serious because it's a potential revenue stream with the advent of ICD 10.

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DR. LARSEN: Right, if you can figure out --

MR. LAMARCA: Until you mentioned it I had forgotten, but the Assembly did draft a bill for community para medicine and it did go to the floor and was successfully passed. So did the Senate -- I didn't hear if the Senate passed the similar bill. So they advanced it forward fairly quickly, Gotfried in the Assembly and I forget who is the Senate --

DR. LARSEN: Dr. Berkowitz and myself attended, there was a big conference of the greater New York Hospital Association on Friday about this whole thing. Anyway, that's definitely moving forward.

DR. ARSHAD: It's a favor actually, for system EMS medical directors when you all start lecturing about BLS CPAP, take five minutes of your meeting to talk about high flow nasal cannula. This issue of New England Journal of Medicine has another article showing dramatic improvement with the use. It's already within the scope of BLS

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and certainly ALS levels and certainly we are advocating for a PEEP valve with every BVM, just lecture on those simple topics.

DR. LARSEN: Okay, anymore under open forum? At this point --

MR. HUGHES: We need it on the record --

DR. LARSEN: Please be advised that as a result of an investigation conducted by the Department of Health the following individuals' New York State certification has been suspended for two months, effective for 8/2015, the suspension is stayed -- the name, Mike Barber, New Babylon, New York. Suspended for six months, effective 4/15/15, the suspension is stayed, placed on three years probation, effective 4/15/15, assessed a civil penalty of $1,000.00 for violation of New York Part 800, 15B and 16G.

Brett McGuire, paramedic certification surrendered effective 4/8/15, allowed to maintain basic certification, expired 6/30/16. Shall not reapply for paramedic certification prior to 6/30/16 for violation of Part 800 16G.

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Gill Hall of Hoosick Falls, New York, suspended for three months effective 2/14/15, placed on probation for three years effective 2/4/15, assessed a civil penalty of $2,000.00. For violation of Part 800 16G Theresa McEare of Castorland, New York -- this too?

MR. HUGHES: Yeah. I think this is the --

DR. LARSEN: Okay, oh, this comes from Sharon Hospital. It is with great pleasure that I announce Dr. Roniel Santos has accepted the role of emergency department director as of May 1st. Please join me in congratulating Dr. Santos in his new role at Sharon Hospital.

DR. BENNEK: Just to clarify, he has not yet gotten a New York license. He is working on that, so until that happens I'll be here and present.

DR. LARSEN: Okay, well, I hope this is a good thing for you. It couldn't come sooner, right?

Okay, with that do I have a motion to

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conclude the meeting?

DR. BENNEK: I'll move.

DR. LARSEN: Second?

DR. MAO: Second.

DR. LARSEN: All in favor?

ALL: Aye.

DR. LARSEN: Opposed?

All abstaining?

Very good. So we'll see you again -- what is the date? We'll see you again after the summer.

THE FOREGOING IS CERTIFIED to be a true and correct transcription of the original Stenographic minutes to the best of my ability.

Yvette Arnold